

Northern Arizona Endodontics

PATIENT INFORMATION

DATE _____

PATIENT (Ms., Mr., Mrs., Dr.) _____
(Last) (First) (M.I.) (Nickname)

MARITAL STATUS: (circle one) Single Married Div. Sep. Widow Widower Child

MAILING ADDRESS _____
(Street) (City) (Zip)

HOME PHONE _____ WORK PHONE _____ SEX: M F

DATE OF BIRTH _____ Social Security Number _____

REFERRING DENTIST _____

EMPLOYER'S NAME _____ OCCUPATION _____

ADDRESS _____
(Street) (City) (Zip)

SPOUSE'S NAME _____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ WORK PHONE _____

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

NAME OF RESPONSIBLE PARTY _____
(Last) (First) (M.I.)

ADDRESS _____
(Street) (City) (Zip)

HOME PHONE _____ WORK PHONE _____ SEX: M F

S.S.# _____ EMPLOYER'S NAME _____

ADDRESS _____
(Street) (City) (Zip)

QUOTED FEES INCLUDE OFFICE VISITS, TREATMENTS, RECALL APPOINTMENTS, ANESTHETICS, X-RAYS, AND MEDICATIONS ADMINISTERED IN THE OFFICE. FEES MAY BE PAID IN THE FOLLOWING WAY (Please check one)
 TOTAL AMOUNT AT THE BEGINNING OF TREATMENT

VISA MASTERCARD DISCOVER CHECK CASH PRE-APPROVED FINANCING

DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ GROUP # _____

ADDRESS _____
(Street) (City) (Zip)

PHONE # _____

NAME OF INSURED PERSON _____ S.S.# _____

DATE OF BIRTH _____ EMPLOYER OF INSURED _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. RODNEY J. BRIMHALL, AND I ALSO AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

DATE _____ SIGNATURE _____

(Patient, or Parent/Guardian of Minor Patient)

PLEASE FILL OUT REVERSE SIDE ALSO

MEDICAL HISTORY

MEDICAL PHYSICIAN NAME _____ PHONE _____

ADDRESS _____

(Address)

(City)

(State)

(Zip)

Please check any of the following which apply to you now or in the past:

	YES	NO		YES	NO		
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	AIDS (HIV Positive)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	_____	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any other diseases or problems? _____

Have you ever had a reaction to an anesthetic or drug such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, Etc.? _____

Medications taking at present _____

WOMEN: Are you pregnant? _____ If so what month? _____

ENDODONTIC TREATMENT LIMITATIONS

The purpose of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require retreatment, surgery, or even extraction. Treatment is usually a non-surgical procedure, but in some cases a surgical approach is necessary. Before any treatment is begun, the reason(s) will be fully explained, including alternative modes of therapy and any possible complications involved. Occasionally, pre-medication may be indicated. This will be discussed in advance.

THE FEE WILL NOT INCLUDE A PERMANENT FILLING OR CROWN ON THE TOOTH. YOU MUST RETURN TO YOUR GENERAL DENTIST TO HAVE THAT TREATMENT COMPLETED.

I ACCEPT ALL RESPONSIBILITY FOR PAYMENT OF DENTAL SERVICES RENDERED AND AGREE TO PAY THE ACCOUNT IN FULL. SHOULD THIS ACCOUNT BECOME DELINQUENT, I AGREE TO PAY ALL COSTS OF COLLECTION AND/OR REASONABLE ATTORNEY'S FEES.

DATE _____ SIGNATURE _____

(Patient, or Parent/Guardian of Minor Patient)

PLEASE, let us know how you're feeling today!



CONFIDENT



OPTIMISTIC



HAPPY



CURIOUS



UNDECIDED



CAUTIOUS



FRIGHTENED



ANXIOUS



PAINED



MISERABLE

DRAW YOUR OWN?